Virginia Employment Commission
First Level Appeals

Name: _____

Address: _____

City & State: _____

Claimant ID #: _____ Telephone Number: _____

I wish to appeal a Deputy's decision: Issue ID #: _____
Benefit Year End (BYE) Date: _____
Overpayment Amount (if applicable): _____

The issue ID and BYE date of your claim are on the decision. If you do not provide the Issue ID and BYE Date on your form, it is not an appeal. We will forward the form to the Customer Call Center for reference if you call for information.

**** If you are appealing a Partial Approval of Overpayment Waiver Request or a Denial of Overpayment Waiver Request, instead of the Issue ID you must provide the Overpayment Amount listed in the Claimant Information box.***

My reason for appealing the Deputy's decision:

_____

_____

_____

Why I filed the appeal after the final date of appeal indicated on the Deputy's decision:

_____

_____

Do you need an interpreter? Yes _____ No _____
If your answer is yes, please provide the language: _____

_____

Signature **Date**

Mail form to:
Virginia Employment Commission
First Level Appeals
P.O. Box 26441
Richmond, VA 23261-6441

Fax form to:
(804) 786-8492

A-FLA-LOA